
State:	Arkansas	Filing Company:	The Independent Order of Foresters
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2012 Change Application		
Project Name/Number:	/		

Filing at a Glance

Company:	The Independent Order of Foresters
Product Name:	2012 Change Application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	10/05/2012
SERFF Tr Num:	FRSS-128688540
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation	On Approval
Date Requested:	
Author(s):	Jennifer Daigle, Kerry Shields, Tamara Levin, Gita Lakhan, Art Vikari, Gale Mcinally
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/10/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 2012 Change Application
Project Name/Number: /

Filing Company: The Independent Order of Foresters

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: The Insurance Laws of Canada where this Society is domiciled does not require approval of this form.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 10/10/2012
State Status Changed: 10/10/2012
Deemer Date: Created By: Kerry Shields
Submitted By: Tamara Levin Corresponding Filing Tracking Number:
Filing Description:
October 4, 2012

RE: Independent Order of Foresters ("Foresters")
NAIC #763-58068; FEIN: 980000680

Dear Sir or Madam:

Forms submitted for approval:

Form Number	Form Description
105735 US 11/12	Application for Change

The form listed above is enclosed for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal industry standards. Approval of this form is not required by the Insurance Laws of Canada where this Society is domiciled.

We have developed an application to be used to apply for changes to our Whole Life, Universal Life and Term life insurance product portfolios as well as any similar products approved in the future.

A separate form, 'Spousal/Additional Insured Coverage - Underwriting Form', 105722 US 10/12, filed and approved on September 13, 2012 under SERFF Filing #: FRSS-128655552, has been created to obtain information regarding insurability of a second person insured under a spouse or additional insured rider, and will be used in conjunction with this Application for Change when the requested change affects such coverage.

While the new form will not be replacing a previously approved form, it will be used in place of the Change portion of an existing filed form – 'Application for Change/Conversion/Reinstatement'. It is our intent to remove that prior form from use completely upon approval and implementation of this Application for Change.

The form can be completed and signed by all applicable parties in hardcopy, traditional format or, if a producer is involved, via electronic application software. Depending on the method of generation and printing, the formatting and fonts may be slightly altered but all content will remain identical to the approved form. The font size will never be less than the required font size.

State:	Arkansas	Filing Company:	The Independent Order of Foresters
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
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- Hardcopy: The forms will be completed by hand and wet signatures would be applied by all signees.
- Electronic: Producers would complete the form using a computer or other mobile device. Producers will be provided with the option of printing the application for wet signature or utilizing an electronic signature process. Our proposed electronic application software is a wizard-based, intelligent fillable forms program. It will ensure that the proper application form is utilized and the information collected is entered correctly, accurately, and securely. When completed electronically the questions and statements on the form will be identical to what was approved. PDFs of the completed form will be presented for review on screen by applicable persons whose signatures are required. Any incorrectly entered data can be corrected at this time prior to signatures being applied.

We certify that security measures will be in place to protect customer privacy. Foresters recognizes that the technology and regulations relating to computers, e-signatures, information security, and delivery is ever-changing and therefore we intend to remain flexible with our approach to ensure we can evolve and upgrade our technology for this process as needed in the future. Foresters confirms that our electronic process will comply with all federal and state regulations relating to digital/electronic signatures and information security, as well as meeting the requirements of all state insurance regulations.

Enclosed please find:

- Application for Change submitted for approval.
- Notices, (MIB and privacy information) as supporting documentation.
- Readability certification.
- Statement of Variability

If I may provide any additional information relating to this submission, please feel free to contact me at 416-429-3000, ext. 4066 or email kshields@foresters.com.

Sincerely yours,

Kerry Shields
Compliance Analyst

Company and Contact

Filing Contact Information

Kerry Shields, Compliance Analyst
789 Don Mills Road
Toronto, ON M3C 1T9

kshields@foresters.com
416-429-3000 [Phone] 4066 [Ext]
416-467-2525 [FAX]

SERFF Tracking #: FRSS-128688540**State Tracking #:****Company Tracking #:**

State: Arkansas**Filing Company:** The Independent Order of Foresters**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other**Product Name:** 2012 Change Application**Project Name/Number:** /

Filing Company Information

The Independent Order of
Foresters

789 Don Mills Road

Toronto, ON M3C 1T9

(416) 429-3000 ext. [Phone]

CoCode: 58068

Group Code:

Group Name:

FEIN Number: 98-0000680

State of Domicile: Ontario

Company Type: Fraternal

Benefit Society

State ID Number:

Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

Company

Amount

Date Processed

Transaction

The Independent Order of Foresters

\$50.00

10/05/2012

63472493

SERFF Tracking #:	FRSS-128688540	State Tracking #:	Company Tracking #:
State:	Arkansas	Filing Company:	The Independent Order of Foresters
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2012 Change Application		
Project Name/Number:	/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/10/2012	10/10/2012

SERFF Tracking #:	FRSS-128688540	State Tracking #:	Company Tracking #:
State:	Arkansas	Filing Company:	The Independent Order of Foresters
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2012 Change Application		
Project Name/Number:	/		

Disposition

Disposition Date: 10/10/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Notices		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Change		Yes

SERFF Tracking #:	FRSS-128688540	State Tracking #:	Company Tracking #:
State:	Arkansas	Filing Company:	The Independent Order of Foresters
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Form Schedule

Lead Form Number:							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		105735 US 11/12	AEF	Application for Change	Initial:	50.200	105735 US 1112_Application for Change.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

The Independent Order of Foresters ("Foresters")

Application for Change

Certificate #: _____

Requested Change(s) (Indicate each change being requested.)

☐ Change to non-smoker classification on: Insured ☐ Spouse/Additional Insured ☐

☐ Rating reconsideration on: Insured ☐ Spouse/Additional Insured ☐

☐ Increase Face Amount to: \$ _____

☐ Change Death Benefit option from (Universal Life Certificates only): Level to Increasing ☐ Increasing to Level ☐

☐ Add/Increase rider benefit:

Rider name: _____ ☐ Add rider \$ _____ ☐ Increase rider to \$ _____

Rider name: _____ ☐ Add rider \$ _____ ☐ Increase rider to \$ _____

Rider name: _____ ☐ Add rider \$ _____ ☐ Increase rider to \$ _____

☐ Other requested changes and/or Remarks: _____

Some changes, if approved, involve charges or require additional payment. Foresters acceptance and/or collection of a payment related to this application is done without prejudice of our right to decline a requested change. No temporary coverage is provided.

Insured Information

First name:		Middle name:		Last name:	
Street address (cannot be a P.O. Box.):					
City:		State:	Zip:	Date of birth (mmm/dd/yyyy):	Social security #:
Home phone #:	Alternate phone # / Cell #:		Email address (optional):		
Occupation & duties:					
Occupation details:					
<input type="checkbox"/> Full time		<input type="checkbox"/> Part time		<input type="checkbox"/> Seasonal	
Income (past 12 months): \$ _____					
Hours worked per week (past 6 months): _____		Number of weeks worked in the past 12 months: _____			

Owner Information (Complete only if the current owner is other than the insured.)

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust:					
Street address (cannot be a P.O. Box.):			City:	State:	Zip:
City:		State:	Zip:	Social security # / Tax I.D. #:	
Phone #:	Alternate phone # / Cell #:		Email address (optional):		

Insured Section

Do not complete this section (Other Insurance, Lifestyle Questions and Medical Questions) if each requested change relates only to a rider that provides Spousal/Additional Insured Term or Children's Term coverage.

Other Insurance (For purposes of these questions "you" and "your" mean the insured.)

1. Do you have another annuity or life insurance application pending with Foresters or another insurer?					O Yes O No
2. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force?					O Yes O No
If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).					
Name of Insurer	Annuity/Life insurance \$	Accidental death \$	Critical illness \$	Disability income (per month) \$	Issue year or indicate if pending
3. Have you ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date _____ and reason _____					O Yes O No

For each "Yes" answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the insured.)

4. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify: Type used: _____ Date last used (mmm/dd/yyyy): _____ If currently smoking, how many pack(s) per day? _____	O Yes O No
5. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	O Yes O No
6. Within the past 10 years have you: a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner? b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs?	O Yes O No O Yes O No
7. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested: O Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____ O Change country of residence: Country : _____	O Yes O No
8. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?	O Yes O No
9. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?	O Yes O No
10. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?	O Yes O No
11. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____	O Yes O No
12. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions: _____ State where each conviction occurred: _____ Date of most recent conviction: _____ (mmm/dd/yyyy) b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If "Yes", provide date(s) and reason(s). _____	O Yes O No O Yes O No

Medical Questions (For purposes of these questions "you" and "your" mean the insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

13. a) Your: Height: _____ Weight: _____ b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: <input type="radio"/> Gain <input type="radio"/> Loss How many pounds? _____ Reason: _____	<input type="radio"/> Yes <input type="radio"/> No																												
14. Date you last consulted a physician: _____ Physician's name: _____ Address: _____ a) Reason(s): _____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	<input type="radio"/> Yes <input type="radio"/> No																												
15. Your personal physician(s), if different than question 14: Name: _____ Phone #: _____ Address: _____ Name: _____ Phone #: _____ Address: _____																													
16. Within the past 5 years, have you consulted a physician other than identified in question 14 or 15, or a medical practitioner, or been a clinic, hospital or emergency room patient?	<input type="radio"/> Yes <input type="radio"/> No																												
17. Are you presently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No																												
18. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No																												
19. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or other hereditary disorder? Details to "Yes" answers to question 19.	<input type="radio"/> Yes <input type="radio"/> No																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Age, if living</th> <th style="width: 15%;">Age, at death</th> <th style="width: 55%;">Details of condition / Cause of death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Siblings</td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Age, if living	Age, at death	Details of condition / Cause of death	Father				Mother				Siblings																
	Age, if living	Age, at death	Details of condition / Cause of death																										
Father																													
Mother																													
Siblings																													
20. Within the past 5 years, have you: a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy? b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No																												

21. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for:	
a) High blood pressure, coronary artery disease, heart murmur, chest pain, irregular heart beat, aneurysm, stroke, Transient Ischemic Attack, circulatory surgery, a disease or disorder of the arteries or circulatory system or had a heart attack or heart surgery?	<input type="radio"/> Yes <input type="radio"/> No
b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system?	<input type="radio"/> Yes <input type="radio"/> No
c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy?	<input type="radio"/> Yes <input type="radio"/> No
d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea, or a disease or disorder of the respiratory system?	<input type="radio"/> Yes <input type="radio"/> No
e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, or a disease or disorder of the brain or nervous system?	<input type="radio"/> Yes <input type="radio"/> No
f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder?	<input type="radio"/> Yes <input type="radio"/> No
g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genito-urinary organs?	<input type="radio"/> Yes <input type="radio"/> No
h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system?	<input type="radio"/> Yes <input type="radio"/> No
i) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system?	<input type="radio"/> Yes <input type="radio"/> No
j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system?	<input type="radio"/> Yes <input type="radio"/> No
k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue?	<input type="radio"/> Yes <input type="radio"/> No

[illegible]

Spousal/Additional Insured Coverage Section

Complete this section ONLY if a requested change relates to a rider that provides

Spousal/Additional Insured Term coverage.

(A Spousal/Additional Insured Coverage – Underwriting Form must also be completed and submitted with this application.)

Spouse/Additional Insured Information

First name:	Middle name:	Last name:
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Children's Term Coverage Section

Complete this section ONLY if a requested change relates to a rider that provides Children's Term coverage.

Children's Questions (For purposes of these questions, "diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner.)

Name of child (First, Middle, Last) under 18 years old (must be a child of the proposed insured)	Gender (M or F)	Date of birth (mmm/dd/yyyy)	Height (ft/in)	Weight (lbs)	Amount of coverage in force

22. Has a child listed above:

a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease? ☐ Yes ☐ No

b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for Human Immunodeficiency Virus (HIV)) that has not yet been started or completed, or the results of which are not yet known? ☐ Yes ☐ No

If "Yes", to either question 22a or 22b, complete the chart below.

Question #	Name of child	Diagnosis, date(s), treatment, present condition	Physician's name, address and phone #

Declarations and Agreements

"Application" means this Application for Change and includes additional forms, if any, that are part of this Application. "Change" means individually each requested change indicated in this Application. "I/Me" means individually each person identified in this Application as either the insured or the owner, and the parent/legal guardian signing this Application if the insured is a juvenile. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters.

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true.

I understand and agree that: 1) The statements and answers in this Application will influence the assessment and acceptance, if any, of the Change(s). 2) The Change(s) approved by us, if any, will be subject to a new two year contestability period based upon the information provided in this Application. 3) No information about me will be considered to have been given to Foresters by me unless it is stated in this Application. 4) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in a loss of coverage or a reversal of the Change(s) made. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 5) A Change to the insurance contract is effective on the date that Change is approved by us provided that: (a) the required payment, if any, is provided in full on or before that date and is honored by the financial institution from which it is to be collected; and (b) between the date this Application was signed and the date that Change to the insurance contract is approved by us, as shown in our records, there is no event, no diagnosed change in health, or no change in the habits or circumstances of the insured or spouse/additional insured, that would require a change to an answer to a question in this Application. 6) If a Change is approved by us, this Application shall form part of the entire contract with Foresters. If a Change is not approved by us, our liability, with respect to that Change, is limited to a refund of the payment collected by us, if any, in relation to that Change.

I further understand and agree that: 1) This Application and related documents may be sent by electronic means. 2) Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 3) If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 4) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing eligibility for the change(s) requested in this Application, (b) adjudicating claims, (c) supporting the Independent Order of Foresters ("Foresters") business operations and (d) record keeping and future servicing by authorized persons. In this authorization: "insured", "owner", and "parent/legal guardian" mean each person identified as such in this Application; "authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business operations. As evidenced by the signature(s) in the Signature Section of this Application, the insured, and owner, on their behalf, or the parent/legal guardian on behalf of the insured if the insured is a juvenile, authorizes Foresters and authorized persons to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or MIB, Inc ("MIB"). This includes obtaining records or other information available as to: past, current or future diagnosis, treatment and prognosis of a physical or mental condition; past, current or future drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. Information may be disclosed: between and among Foresters and authorized persons; to companies to which the insured has or may apply to for life or health insurance, or benefits; as required or permitted by law. The insured, and owner, on their behalf, or the parent/legal guardian on behalf of the insured if the insured is a juvenile, authorizes Foresters and authorized persons, to make a brief report of the insured's personal and/or protected health information to MIB, even if this Application is cancelled or withdrawn. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this Application. A copy of this authorization shall be as valid as the original. Each person signing this authorization may at any time, by written notice to Foresters, revoke their authorization, except that reporting to MIB and action(s) begun before receipt of notice will not be affected. A Notices page has been provided to the insured. It includes the MIB and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

Signature Section (For purposes of entire Application.)

Insured's signature: X _____
(If the insured is not a juvenile.)

Owner's signature: X _____
(If other than insured.)

The owner or the insured, if the insured is the owner, signed on _____.
(mmm/dd/yyyy)

Parent/Legal guardian's name (print full name): _____
(If the insured is a juvenile and the owner is not a parent/legal guardian.)

Parent/Legal guardian's signature: X _____

SERFF Tracking #:	FRSS-128688540	State Tracking #:	Company Tracking #:
State:	Arkansas	Filing Company:	The Independent Order of Foresters
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR_Readable Score Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Notices		
Comments:			
Attachment(s):			
105744 US 1112_Notices Final.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
AR_Statement of Variability.pdf			

The Independent Order of Foresters

NAME OF COMPANY: The Independent Order of Foresters
Forester House, 789 Don Mills Road, Toronto, Ontario M3C 1T9
(416) 429-3000

A. Option Selected

- ☐ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is below.
- ☒ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below.

Form and Form Numbers to which Certification is Applicable:

<u>Form Name</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application for Change	105735 US 11/12	50.2

B. Test Option Selected


- ☒ 1. Test was applied to entire policy form(s).
- ☐ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

- ☒ 1. The policy text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- ☒ 2. It is printed in not less than 10-point type, one point leaded. (This does not apply to specification pages, schedules and tables).
- ☒ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
- ☒ 4. The section titles are captured in bold-faced type or otherwise stand out significantly from the text.
- ☒ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
- ☒ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
- ☐ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

This certification must be signed by an officer of the insurer.

 Digitally signed by ca, Tamara Levin
DN: c=ca, o=iofentrust,
cn=ca, ou=ciscovpn,
cn=Tamara Levin
Date: 2012.10.04 14:31:00
-04'00'

October 4, 2012

Hendrik Verdurmen
Vice President, Finance & Product Management

Date

Notices (This page must be given to the insured.)

For purposes of this Notice the following words and phrases are defined: "Application" means the Application for Change to which this Notice relates; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business operations; "You" and "Your" mean individually the insured and each child, if any, identified in the Application. If you have questions regarding your Application contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. Box 179, Buffalo, NY 14201-0179.

Privacy - Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization between and among Foresters and authorized persons, to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, to companies to which you have applied for insurance coverage or benefits, and to those conducting bona fide actuarial, marketing or scientific studies or audits and the respective employees, agents, contractors and consultants of each of the aforementioned. We may also disclose information to your physician and MIB, Inc. ("MIB"). You can make a request to review personal information about you in our file. However, we will not disclose information to you that was prepared for an anticipated claim, civil or criminal proceeding. You may request correction of information which you believe to be inaccurate or irrelevant. Upon request, we will provide more information about these procedures.

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested change(s) indicated in the Application. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. The federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

MIB, Inc. - Information regarding your insurability will be treated as confidential. Foresters or authorized persons may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

The Independent Order of Foresters

Statement of Variability

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1. Foresters head office and US mailing addresses, telephone number, website and corporate logo are bracketed to allow for change if Foresters moves, rebrands or changes its phone number.

All Pages, footer

1. The 'form identifier', when present, is used by a Foresters form tracking system for administrative purposes only. Example – may be a bar code or serial number.